



# Oregon

Theodore R. Kulongoski, Governor

**Oregon Medical Board**  
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Dear Doctor:

The following documents comprise the application packet for licensure as a volunteer emeritus medical or osteopathic physician (MD/DO) to practice in a health clinic in the State of Oregon:

- General Information on the licensure process
- Instructions for completing the application form
- Application form
- Forms for verification of training, employment, etc.

Definition of "health clinic," per Senate Bill 443 (2005) means a public health clinic or a health clinic operated by a charitable corporation that mainly provides primary physical health, dental or mental health services to low-income patients without charge or using a sliding fee scale based on the income of the patient.

Definition of Emeritus status for a licensee is one who has retired from active practice but does only volunteer, non-remunerative practice and receives no direct monetary compensation. Physicians with emeritus registration pay an annual registration fee of \$50.00 which is effective from January 1 to December 31 of each year.

There is no application fee for out-of-state physicians applying for a volunteer emeritus license to practice in a health clinic using the above definition.

**READ ALL INSTRUCTIONS** - Please read all instructions and the general information on licensure BEFORE completing the application. You must complete all parts of the application form and send it to the Board. Please make a copy of the completed application form for your own records. You may make as many copies of the various verification forms as you need to send to the different sources for verification of state licensure, training, employment, etc.

**PROCESSING AN APPLICATION** - Applications are processed in date order received, and on average take eight weeks to complete. If you have malpractice or disciplinary history, or derogatory information is received by the Board, it may take three months or longer to complete your application file.

**ONLINE STATUS REPORT** - As soon as your application and items received are entered on our database, you will receive a letter notifying you of your applicant number with instructions to access the Online Status Report. The OSR will provide you with the status of your application: items received and items still needed to complete your application file. The OSR is updated as items are received and entered into the licensing database. The OSR will tell you when your file is complete.

**STREAMLINING THE APPLICATION PROCESS** – In order to speed up the application process, the Board has eliminated:

- Military Separation Paper (DD214)
- ECFMG Certificate
- LMCC Certificate
- Postgraduate training certificate
- AMA/AOA Physician profile

The Board has also reduced the verification of employment to only the past 5 years instead of the current 10 years. If the applicant has not practiced for the more than 2 years, the Board requires verification of employment for the past 10 years.

Board staff will obtain the NPDB-HIPDB Self-Query for the applicant, and the results of the Federation of State Medical Boards' Board Action Database Inquiry. This speeds up the processing time and saves the applicant the fee for the Self-Query.

For applicants who were initially licensed a number of years ago, the Board will accept a certified copy from another state medical board of the Dean's Letter, Verification of Medical Education, medical school diploma, and postgraduate training verifications in lieu of direct source verification.

**QUESTIONS?** - If you have any questions that are not answered by reading the general information on applying for a license and the application instructions, you may telephone the Board office at the above number between 9:00 AM and 4:00 PM. If we are busy, we will return your telephone call within 24 hours during the business week.

Sincerely,

Licensing Department  
Oregon Medical Board

## GENERAL INFORMATION

### FILE PROCESSING

Applications are processed in date order received. An applicant number will be assigned during processing. This number is different from your future license number. The applicant number will provide you access to the Board's **Online Status Report**. Processing an application file means entering detailed information provided on your application form into the application database. This allows staff to determine which items have already been received, and which items are still needed to complete your file. Until this information has been entered into our database, we are unable to advise you of which items may still be needed and your Online Status Report will not reflect the Board's receipt of the documents.

### ONLINE STATUS REPORTS

When your application has been initially processed, you will receive a letter notifying you of your applicant number with instructions to access the Online Status Report (OSR) on the Board's website at [www.oregon.gov/OMB](http://www.oregon.gov/OMB). If items continue to be shown as outstanding on your status report, you may wish to request the items from the source again. All required documents, letters, forms, etc., must be in your file before it is considered complete. Faxed documents are not acceptable.

### FILE COMPLETE and INITIAL REGISTRATION

When your file is complete, you will be sent the initial registration materials. If your application is more than six months old, you will also be sent an update form that is required prior to licensure. If these forms and fee are submitted **within three months of the date sent by the Board**, the license will be issued on the date the payment is received. However, if the forms and fee **are not submitted within three months**, you would be required to update your application for licensure by completing an affidavit. If the forms and fee **are not submitted within 12 months from the date your application was received in the Board office**, you will be required to file a new application for licensure with documents, verifications, and letters as if filing for the first time.

### NO PERSONAL INTERVIEW REQUIRED FOR LICENSURE

Applicants whose file is complete with **NO DEROGATORY INFORMATION** are **NOT** required to appear before the Board in person as a part of the licensure process. The licensure process will be completed by mail. The Board, however, **may require a personal interview** if there are concerns to be discussed with the applicant regarding information received during the processing of the application file. If a personal interview is required, you will be advised in writing several weeks prior to the scheduled meeting of the Board.

### EXPRESS LICENSING

Applicants whose file is complete and from whom the Board has received the initial registration form and fee will be added to the list of applicants to be approved for licensure by the Board's Executive Director each week. If the Executive Director is unavailable to approve the list for a given week, approval will be delayed until the Executive Director's return.

### FEDERATION CREDENTIALS VERIFICATION SERVICE (OPTIONAL)

The Federation Credentials Verification Service (FCVS) provides a service to physicians that for a fee, gathers information and verifications of *core credentials* to be kept on file for use by state medical boards and other organizations. The Oregon Medical Board accepts the portfolio from this service in lieu of some of the Board's application process. *However, the FCVS portfolio is NOT REQUIRED.* The information received from FCVS does not include all items required by the Oregon Board. **The Board's application form, fees, and additional documents required to meet the licensure requirements of the Board and to complete the application file will still be needed.** An on-line physician application is available through the Federation of State Medical Board's website at <http://fcvs.fsmb.org/>, or call 888-ASK-FCVS.

## ELIGIBILITY REQUIREMENTS FOR VOLUNTEER EMERITUS LICENSURE IN OREGON

An out-of-state physician may apply for a volunteer emeritus license if the physician will be volunteering at a public health clinic or a health clinic operated by a charitable corporation that mainly provides primary physical health, dental or mental health services to low-income patients without charge or using a sliding fee scale based on the income of the patient. The volunteer emeritus physician in Oregon does only volunteer, non-remunerative practice and receives no direct monetary compensation. In order for you to determine eligibility for volunteer emeritus licensure in the state of Oregon, please read the following:

### US/CANADIAN GRADUATES

1. Graduate of a medical school accredited by the Liaison Committee on Medical Education, the American Osteopathic Association or the Canadian Medical Association. By Oregon law, this Board requires that an osteopathic physician issued a diploma as a Doctor of Medicine as a part of the California Unification Program must be licensed in Oregon as an osteopathic physician.
2. The Board has approved some medical schools in England, Scotland, Ireland, and Australia. Contact the Board if you attended medical school in one of these countries.
3. Pass a national medical licensing examination (FLEX, NBME, NBOME/COMLEX, USMLE) or combination examinations (NB, NBOME, USMLE completed prior to 1/1/2000).
4. Satisfactory completion of one year of internship, residency, or clinical fellowship training accredited by the Accreditation Council for Graduate Medical Education, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Association.

### FOREIGN MEDICAL GRADUATES

1. Graduated from a medical school listed in the World Health Organization's "World Directory of Medical Schools." The medical school must be chartered in the country in which it is located. The applicant must have attended at least four full terms of on-site instructions of 8 months each, with all courses having been completed by physical on-site attendance in the country in which the school is chartered.
2. Pass a national medical licensing examination (FLEX, NBME, NBOME/COMLEX, USMLE) or combination examinations (NB, NBOME, USMLE completed prior to 1/1/2000).
3. Obtained the Standard ECFMG certificate.
4. Satisfactory completion of an internship, residency, or clinical fellowship in the US or Canada of three years of progressive training in not more than two training programs accredited for internship, residency or fellowship training by the Accreditation Council for Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Association.

### ECFMG/FMGEMS (FIFTH PATHWAY TRAINING)

Graduates of foreign medical schools must have obtained the Standard ECFMG certificate issued by the Educational Commission for Foreign Medical Graduates; Fifth Pathway applicants must submit proof of passing ECFMG or FMGEMS examination.

## EXAMINATIONS (BASIS FOR LICENSURE)

### USMLE – United States Medical Licensing Examination

Oregon requires that applicants pass USMLE per the rules below:

- **Pass USMLE Steps 1, 2 and 3 within 7 years**  
USMLE Steps 1, 2 and 3 must be passed within a seven-year period which begins when the first Step, either Step 1 or Step 2, is passed. **An applicant may request a waiver**, if he/she has:
  1. Current certification by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; or
  2. Suffered a documented significant health condition which by its severity would necessarily cause a delay to the applicant's medical or osteopathic study; or
  3. Participated in a combined MD/DO/PhD program; or
  4. Completed continuous postgraduate training with the equivalent number of years to an MD/DO/PhD program.

- **USMLE Step 3 – pass in 4 attempts**

Step 3 must be passed within four attempts. After the third failed attempt, the applicant must complete a full year of Board approved postgraduate training in the United States or Canada prior to taking USMLE Step 3 on the fourth and final attempt. **An applicant may request a waiver**, if he/she has current certification by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists.

#### **NATIONAL BOARD OF MEDICAL EXAMINERS**

Applicant has passed the examination and is certified by the National Board.

#### **NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS**

Oregon requires that applicants pass NBOME/COMLEX per the rules below:

- **NBOME/COMLEX – Levels 1, 2 and 3 within 7 years**

NBOME/COMLEX Levels 1, 2 and 3 must be passed within a seven-year period which begins when the first Level, either Level 1 or Level 2, is passed. **An applicant may request a waiver**, if he/she has:

1. Current certification by the American Osteopathic Association's Bureau of Osteopathic Specialists; or
2. Suffered a documented significant health condition which by its severity would necessarily cause a delay to the applicant's medical or osteopathic study; or
3. Participated in a combined MD/DO/PhD program; or
4. Completed a continuous postgraduate training with the equivalent number of years to an MD/DO/PhD program.

- **NBOME/COMLEX Level 3 – pass in 4 attempts**

NBOME/COMLEX Level 3 must be passed within four attempts. After the third failed attempt, the applicant must complete a full year of Board approved postgraduate training in the United States or Canada prior to taking and passing NBOME/COMLEX Level 3 on the fourth and final attempt. If the fourth attempt of COMLEX Level 3 is failed, the applicant is not eligible for Oregon licensure. If the applicant did not complete a full year of training approved by the Board between the third and fourth attempt to pass COMLEX Level 3, the applicant is not eligible for Oregon licensure. **An applicant may request a waiver**, if he/she has current certification by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists.

#### **FLEX LICENSING EXAMINATION TAKEN ACCORDING TO OREGON'S STANDARDS**

- FLEX Weighted Average of 75 (examinations administered from 6/68-12/84, taken in one sitting) or Component 1 and 2 scores of 75 on each Component (examinations administered from 6/85 -12/94 may be taken together or separately).
- Passed within three attempts.
- After the third failed attempt, the applicant must have satisfactorily completed one year of approved training in the US or Canada prior to taking the entire FLEX examination at one sitting on the fourth and final attempt.
- Component 1 and Component 2 must have been passed within seven years of the first attempt. Only the applicant's scores on the most recently taken FLEX examination will be considered to determine eligibility.

#### **FLEX WAIVER**

Successful completion of the FLEX examination in another state according to Oregon's standards WITHOUT obtaining a state license based on these FLEX grades.

#### **LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (LMCC)**

Applicant has passed the examination and is certified by the Medical Council of Canada.

## HYBRID-COMBINATION EXAMINATIONS

Accepted Examination Sequence	Acceptable Examination combinations if completed prior to January 1, 2000
NBME Part I plus NBME Part II plus NBME Part III	NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Part II plus Plus NBME Part III or USMLE Step III
FLEX Component 1 plus FLEX Component 2	FLEX Component 1 plus USMLE Step 3  NBME Part I or USMLE Step I plus NBME Part II or USMLE Step 2 plus FLEX Component 2

### MEDICAL PRACTICE ACT (MPA) & DRUG ENFORCEMENT ADMINISTRATION (DEA) LAWS OPEN-BOOK EXAMINATIONS

Study material and two open-book examinations on Oregon laws and rules as well as Federal DEA laws are included in your application. This material must be reviewed, completed and returned to the Board toward completion of your file.

### GROUND S FOR DENIAL OF OREGON LICENSURE

An applicant may not be entitled to be granted a license by reciprocity, endorsement or written examination who:

- Has had a license revoked or suspended in this or any other state unless the said license has been restored or reinstated and the applicant's license is in good standing in the state which had revoked the license;
- Has been refused a license or certificate in any other state or country on any grounds other than failure in a medical licensure examination; Has been guilty of conduct similar to that which would be prohibited by or to whom ORS 677.190 would apply.

### NARCOTIC STAMP/DEA REGISTRATION

Oregon law does not require that a physician apply for a **state** NARCOTIC STAMP. The Oregon Board does not issue DEA registration. To obtain your **Federal DEA number**, it is suggested that you contact the DEA Field office at 400 2nd Avenue, West, Seattle, Washington 98119, (888) 219-4261, to advise that you are applying for an Oregon license. Most likely you will be requesting a Change of Address Form. If you are re-applying for DEA registration, please be aware that their application becomes invalid after 40 days so do not submit your application to the DEA until 40 days prior to the date you wish to practice in the State of Oregon.

### ENGROSSED LICENSE -- WALLET CARDS -- CERTIFICATE OF REGISTRATION

When your license is granted, your first proof of licensure will be the wallet license card, followed by the Certificate of Registration and formal engrossed license. The Certificate of Registration will be mailed to you within two to three weeks of your license being granted. The wallet card and formal engrossed license will be mailed within one month of your license being granted. These documents will show the following information:

- **Wallet license card**- Name, license number and date issued
- **Certificate of Registration**- Name, address, license number, date issued and date of expiration, and status (Active, Inactive, etc.)
- **Formal engrossed license**- Name, license number and date issued

**SPECIAL PURPOSE EXAMINATION (SPEX)  
or  
COMPREHENSIVE OSTEOPATHIC MEDICAL VARIABLE-PURPOSE EXAMINATION (COMVEX)**

Physician applicants (MD/DO) may be required to take the SPEX or COMVEX examination if completion of postgraduate training, Board certification or recertification was obtained 10 or more years prior to filing an application for Oregon licensure, or the applicant ceased practice for 12 or more consecutive months. The purpose of these examinations is to determine current medical knowledge. These exams are given on an ongoing basis. If an examination is required, Oregon practice would be delayed until the examination has been passed.

<b>Conditions Under Which SPEX or COMVEX May Be Required</b>	<b>SPEX or COMVEX Requirement May Be Waived if Applicant Has Subsequently:</b>
A. An applicant whose initial license or Board certification was obtained 10 or more years prior to filing an application for Oregon licensure	<ul style="list-style-type: none"> <li>• Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) within past ten years</li> <li>• Completed one year of an accredited or Board approved residency or clinical fellowship training program within past ten years</li> <li>• Provided documentation of continuing medical education to the Board's satisfaction, obtained in recent years</li> </ul>
B. An applicant who has ceased practice for 12 or more consecutive months	<ul style="list-style-type: none"> <li>• Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA)</li> <li>• Completed additional postgraduate or fellowship training</li> <li>• Provided documentation of continuing medical education to the Board's satisfaction, obtained during months or years when not practicing</li> </ul>

***Request for Waiver***

If you wish to request a waiver of the SPEX or COMVEX examination, you must submit a request in writing and provide documentation of continuing medical education for the past 1-3 years, or have a letter sent directly to the Board stating you have been granted an appointment as a professor or associate professor at the Oregon Health and Science University.

Your request will be reviewed by the Board's Executive Director who may grant a waiver of the examination depending on how long you have been out of practice, or your request may be referred to the Administrative Affairs Committee (AAC) of the Board for review at their next meeting. This will require that ALL processing of your file be complete by at least one month prior to the AAC meeting. The AAC meets quarterly, each March, June, September and December. The dates of the AAC meetings can be found at <http://egov.oregon.gov/BME/phyappdeadlinedates.shtml>.

Further details for requesting a waiver of the SPEX can be seen at Notice to Oregon SPEX Applicants and Request for SPEX Waiver ([http://egov.oregon.gov/BME/MD-DO\\_Application/Spex-Exam-memo.pdf](http://egov.oregon.gov/BME/MD-DO_Application/Spex-Exam-memo.pdf)).

**Limited License, SPEX or COMVEX**

If an applicant meets all requirements for licensure, except that the SPEX or COMVEX examination is required, the Board may grant a Limited License, SPEX **for a period of six months** when the application file is complete, and the applicant has a definite Oregon location. The limited license registration form must be completed and the fee submitted before the limited license can be issued. The applicant must complete both the SPEX or COMVEX examination and the volunteer emeritus licensure process prior to the expiration date of the Limited License, SPEX or COMVEX as the limited license cannot be extended or reissued.

If the physician fails to pass the SPEX or COMVEX examination, the limited license will become invalid and the physician must cease practice in Oregon as soon as possible, but not to exceed two weeks. The Limited License, SPEX or COMVEX allows the applicant to apply for DEA registration, malpractice insurance, etc. Do not submit the fee for a Limited License, SPEX or COMVEX until it is requested by the Board.

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# INSTRUCTIONS FOR COMPLETING YOUR VOLUNTEER EMERITUS LICENSE APPLICATION

## INTRODUCTION

- Please be advised that fraud or misrepresentation in applying for or procuring a license to practice medicine in Oregon is grounds for denial of your application.
- Complete the application yourself. Do not delegate this important task to someone else. If you do and the information on the application is not correct, it will delay the processing of your application and could delay the Board granting you a license to practice in Oregon.
- Take your time and read the instructions and the form carefully. Do not rush through the application.
- All applicants, despite the basis used to obtain licensure, must complete all forms that pertain to the applicant's history. Licensure is not granted solely on passing a licensure examination, and passing a licensure examination does not assure issuance of an Oregon license.
- Information must be completed on the original application form; a copy is not acceptable.
- The application form and documents submitted to the Board will not be returned to you. For your own records and for reference during the licensure process, keep a copy of your application and all forms that you send to a third party.
- Provide full details and dates, and complete names, addresses and zip codes where requested.
- Each item on the application form must be completed. If an item of information is not relevant to your application, please write in "Not Applicable" or "N/A".
- If additional space is needed to answer any of the questions on the application, please continue on a separate sheet, indicate to what question your response is relevant, print your name, sign and date it, and submit it with the application form.
- The Board must receive all application materials and supporting documentation in the mail or you may hand deliver them to the Board office. The Board does not accept faxed documents.
- The following information is provided in order to assist you in answering the questions on the licensure application. Please review your completed application prior to mailing it to the Board to be sure all items have been completed. Incomplete or incorrect information will delay the processing of your application. You are responsible for the contents of your application even though someone else may assist you in its completion.

## FEES

**There is no application fee for licensure as a physician registering with volunteer emeritus status**

### **Initial MD/DO Registration and Biennial Registration Fees**

Initial registration fees are due prior to licensure being granted. Emeritus registration is for one year and the annual fee is \$50.00. After initial licensure, annual registration (January 1 to December 31) fees are due to maintain your Oregon license.

### **Other Fees**

If an applicant is required to take the SPEX examination, all fees due to take this examination will be requested by and paid directly to the Federation of State Medical Boards. SPEX examination fees should not be submitted to the Oregon Medical Board.

### **Verification Fees -- State Boards, Hospitals, Medical Schools**

Any fees requested by an agency to provide a verification of licensure, training, graduation, etc., are the responsibility of the applicant.

## HOW TO FILL OUT THE APPLICATION

- Item 1** Full legal name as it appears on Birth/Marriage certificate or naturalization/name change documents only
- Item 2** Show any names you have used professionally in the past or other names you have been known by
- Item 3** Practice address.
- Item 4** Residence address
- Item 5** Other address (Use this section only if you wish your mail to be sent to a billing agency, a relative, etc.)
- ✓ Mail will be sent to the address you designated for mailing purposes. Please arrange to have mail forwarded to you. Review your Online Status Report closely for items still needed to complete your file.
- Item 6** Practice/training telephone number (office, clinic, hospital, etc.) with proper area code and extension
- Item 7** Residence telephone number with proper area code
- Item 8** Other telephone number with proper area code
- Item 9** E-mail address. Provide your e-mail address if you wish to receive e-mail communications on the status of your application as it progresses through the application process. Please be aware that e-mail is not a secure medium of communication and that e-mail may contain confidential (personal) information.
- Item 10** Social Security Number required.
- ✓ As part of your application for license or renewal of your registration you are required to provide your Social Security Number to the Oregon Medical Board. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC § 666(a)(13), 42 USC § 405 (c)(2)(i) and 45 CFR § 61.7 (3)(b). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the license, certification or registration you seek. Your Social Security Number will remain on file with the Board and will be used for child support enforcement by Child Services Division, for tax administration and required reports to the National Practitioner Databank and the Healthcare Integrity and Protection Databank (NPDB-HIPDB). The Board may also use your Social Security Number for identification and investigative purposes and for the collection of delinquent fines assessed by the Board.
- Item 11** Premedical/preosteopathic school - name, location, beginning and ending dates, degree and date obtained.
- Item 12** Information on additional premedical/preosteopathic education, if any.
- Item 13** Name and location of all medical/osteopathic schools attended, with beginning and ending dates of attendance for each year enrolled, showing repeated years, or gaps in education or leaves of absence.

- Item 14** Name and location of medical/osteopathic school you graduated from, with date of graduation, and degree obtained.
- Item 15** Indicate which licensure examination(s) you have taken. Indicate other examination(s) taken such as ECFMG/FMGEMS or SPEX.
- Item 16** List ALL licenses ever applied for whether they are pending, active or inactive, temporary (for training), or have been denied, suspended or revoked, or your application was withdrawn. Provide full written explanation if you have had a license denied, suspended, or revoked, or if you withdrew an application for licensure.
- Item 17** Indicate if you have ever applied for or obtained ANY medical license in Oregon. If so, list license number and date issued.
- Item 18** **List all hospitals in which you have ever applied for staff privileges for practice or military service, from the date of medical school graduation to the present date.** The list should include the beginning and ending dates, complete names and addresses and zip codes of the hospitals and other required information. Do not include hospital training programs. Verifications are required for the past five (5) years only.
- Item 19** **Account for all periods of time since you graduated from medical/osteopathic school to the present date.** This should include any non-medical activities, vacations, (of one month or longer and only between activities), training, or postgraduate work, private practice, staff positions or locum tenens. It should include the beginning and ending dates, complete names, addresses and zip codes and the type of training or postgraduate work, or hospitals, clinics and the type of position-employment held in each location. Indicate the number of physicians in the group or clinic and the name of the clinic manager or director, if applicable. Verifications are required for the past five (5) years only.

**Item 20 PERSONAL HISTORY QUESTIONS**

If you answer "YES" to any personal history question, please furnish details on the form provided by the Board, sign and date it, and submit it with your application. The source must submit a letter and/or documents relevant to the situation directly to the Board. Failure to provide all details will delay the processing of your file.

<b>CATEGORY I</b>
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<b>Question 1</b>	
<b><i>Applicant</i></b>	Provide full details to include date of licensure, license number, type of license, and current status of the license.
<b><i>Licensing Board</i></b>	Provide verification of licensure to include license number, date issued, current status.
<b>Question 2</b>	
<b><i>Applicant</i></b>	Provide full details to include state/province, type of examination failed, and dates and grades (if known) for each failure.
<b><i>Examination Agency</i></b>	The report of examination grades will verify any failed attempts.
<b>Question 3</b>	
<b><i>Applicant</i></b>	Provide full details to include state/province, reasons/circumstances and

	any disciplinary action.
<b>Licensing Board</b>	Provide full details and include copies of any legal documents.
<b>Questions 4 and 5</b>	
<b>Applicant</b>	Provide states, dates and reasons/circumstances.
<b>Licensing Board</b>	Provide full details and include copies of any legal documents.
<b>Question 6</b>	
<b>Applicant</b>	Provide full details including dates and reasons/circumstances, and provide a copy of documents, reports and correspondence.
<b>State Narcotic Office/Drug Enforcement Administration (DEA)</b>	Provide full details and include copies of any legal documents.
<b>Question 7</b>	
<b>Applicant</b>	Provide full details of the arrest, the dates, places, and disposition of the case.
<b>Police Department/Court</b>	Provide a Certified Copy (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order or other such documents which reflect the disposition of the matter.
<b>Question 8</b>	
<b>Applicant</b>	Provide full details to include the agency conducting the investigation as well as the reasons for the criminal, civil, or licensing investigation. Provide a copy of documents, reports and correspondence.
<b>Investigating Agency</b>	Provide full details concerning reasons for the investigation.
<b>Question 9</b>	
<b>Applicant</b>	Provide full details to include details of the case, where/when incident occurred, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of the documents, reports and correspondence.
<b>Court</b>	Provide full details concerning reasons for the investigation.
<b>Question 10</b>	
<b>Applicant</b>	Provide full details to include the agency/party with which the settlement was entered as well as the reasons for and conditions of the settlement. Provide a copy of the documents, reports and correspondence.
<b>Agency/Party</b>	In some cases information is needed in addition to the applicant's explanation (see below).
<b>Question 11</b>	
<b>Applicant</b>	Provide full details to include name of patient, where/when incident occurred, disposition of the case, judgment, etc. Please indicate if the case is still pending. Provide a copy of the documents, reports and correspondence.
<b>Malpractice Carrier/Court</b>	In some cases information is needed in addition to the applicant's explanation. (see above)

<b>Question 12</b>	
<b>Applicant</b>	Provide the length of time you did not practice medicine or ceased the practice of your specialty and the reason why, as well as your activities, <b>(medical or non-medical)</b> for that period of time.
<b>Hospital/School/ Training Program</b>	In most cases, the applicant's explanation is all that is needed concerning an affirmative response to question 12. However, in some cases the applicant will be asked to request information be sent directly from other sources to the Board.
<b>Question 13</b>	
<b>Applicant</b>	Provide name of the medical/osteopathic/podiatric school, training program, dates and reasons/circumstances.
<b>School/ Training Program</b>	Provide full details concerning the circumstances, results, and copies of any legal documents.
<b>Question 14</b>	
<b>Applicant</b>	Provide full details to include the name of the hospital, clinic, surgical center, dates, and reasons/circumstances.
<b>Hospital/ Employment</b>	Provide full details, including dates, circumstances, results, and copies of any legal documents.

**CATEGORY II**

<b>Question 1</b>	
<b>Applicant</b>	Provide full details and dates regarding treatment received for the condition. If any medications were prescribed, furnish the names, dosages and the dates the medications were taken. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment, or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
<b>Source</b>	Provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent. Letters/reports to be sent directly to this Board.
<b>Question 2</b>	
<b>Applicant</b>	Provide full details and dates regarding this treatment. If any medications were prescribed, furnish the names dosages and the dates the medications were taken. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
<b>Source</b>	Treatment provider to furnish complete details of treatment or counseling Including dates, diagnosis (if any), treatment and prognosis. Request the Appropriate official at the hospital send directly to the Board a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent. Letters/reports need to be sent directly to this Board.

<b>Question 3</b>	
<b><i>Applicant</i></b>	If you received treatment for this dependency, provide full details and dates regarding this treatment. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
<b><i>Source</i></b>	Treatment provider to furnish complete details of treatment or counseling Including dates, diagnosis (if any), treatment, and prognosis. Request the appropriate official at the hospital send directly to the Board a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the Equivalent. Letters/reports to be sent directly to this Board.
<b>Question 4</b>	
<b><i>Applicant</i></b>	Provide full details and dates regarding this treatment and/or hospitalization. Include the names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist, or counselor and dates of treatment or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis. If you have been arrested for a DUII or DWI, request for the arresting officer's report and court documents to be sent directly to this Board.
<b><i>Source</i></b>	Provide a full report to include Family History/Physical; Individual Assessment and Evaluation; Psychiatric Evaluation; Psychosocial Assessment; Discharge Summary and Discharge Plan for Continued Care or the equivalent. <b>Police Department/Court</b> to provide a Certified Copy (with court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order or other such documents which reflect the disposition of the matter. Letters/reports to be sent directly to this Board.
<b>Question 5</b>	
<b><i>Applicant</i></b>	If you received treatment related to this chemical substance screening test, provide full details and dates regarding treatment. Include names and addresses of the treating psychiatrist, psychologist, social worker, clinical therapist or counselor and dates of treatment or therapy. Request the person providing treatment send directly to the Board complete details of treatment or counseling including dates, diagnosis (if any), treatment and prognosis.
<b><i>Source</i></b>	Furnish complete details of treatment or counseling including dates, Diagnosis (if any), treatment and prognosis. Hospital report is also needed to include Family History, Physical, Individual Assessment and Evaluation, Psychiatric Evaluation, Psychosocial Assessment, Discharge Summary and Discharge Plan for Continued Care or the equivalent. Letters/reports to be sent directly to this Board.
<b>Question 6</b>	
<b><i>Applicant</i></b>	Provide full details and dates to include the name and location of the diversion program, regulatory board, healthcare program or facility, and/or court, and reasons for and results of entering the program.
<b><i>Source</i></b>	Furnish treatment records and any court/legal documents directly to the Board.

- Item 21** Indicate month, day and year of birth.
- Item 22** Indicate city, state, or country of birth if not in the United States.
- Item 23** Describe your physical appearance.
- Item 24** Indicate your gender: male or female.
- Item 25** Indicate beginning and ending dates of **ALL** active duty in the military service.
- Item 26** If you have a medical specialty, please indicate the specialty.
- Item 27** Indicate where you plan to practice (hospital, clinic, with another physician, solo practice), the practice address, and the beginning date of practice. If your place of practice is undecided, indicate "undecided".
- Item 28** Provide information on initial certification and recertification by an American Specialty Board recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Medical Specialists.

**Photograph:** Attach photograph in this space by stapling it to the application. Photograph should be an original of passport quality, a close-up front view of head and shoulders (not a profile). Photograph must be taken within 90 days prior to applying, signed in ink on the front, showing date taken. Photograph may not be computer generated or scanned.

**Release/Affidavit of Applicant:** You must complete this affidavit in the presence of a Notary Public. The Notary Public must sign, date, and affix seal to the affidavit. The notarization must be placed directly on the application.

#### **DOCUMENTS TO BE SUBMITTED BY THE APPLICANT**

**Size of Documents:** Documents submitted must be legible, and no larger than 8 1/2 x 11 inches, and no smaller than 5 x 7 inches. If the original document is larger or smaller than this, please have the copy reduced or enlarged to 8 1/2 x 11 inches to show all wording, dates and signatures.

**Copies of Original Documents:** Do **not** submit original documents. Copies do not need to be notarized. Any documents submitted become a part of your file and will not be returned to you. Xerox copies of documents are acceptable, but must be legible. Translations of foreign documents are required (see below).

**Official Translations:** If any of your documents are in a foreign language (except Latin), this Board requires you to furnish an official, word-for-word translation of that document. Acceptable translators are an employee of a professional translating company, or a member of the American Translation Association, or a faculty member of the modern languages or linguistics department of a United States college or university. The translation must be on official letterhead, and bear the translator's certification seal. **Translations will not be returned to the applicant.** All information appearing on the document must also appear on the translation each time it appears on the original document. This includes pre-printed information, such as the letterhead of a university, titles, etc. The translation must be attached to the copy of the document being translated. The applicant is required to pay for all translated documents.

**Birth Certificate:** Provide a copy of official birth certificate or birth record. Hospital birth certificates are **not** acceptable. Your application must show your complete, legal name including Jr., II, III, initial only, or no middle name. Your complete, legal name will be shown on your formal license, and all licensees must pursue their profession under their own name as it appears on the license. A copy of your **passport, driver's license**, etc., does **not** meet this requirement and cannot be accepted in lieu of the required birth certificate.

**Change of Name/Marriage Certificate:** A copy of Change of Name documentation, Marriage Certificate, or Divorce Decree if your name has been changed by court order, adoption, marriage, divorce, etc.

If you have had a name change due to marriage, divorce, adoption, court order or naturalization, furnish a copy of all applicable documents as follows:

- Marriage furnish a copy (no larger than 8 1/2 x 11 inches) of your marriage certificate
- Divorce furnish a copy (no larger than 8 1/2 x 11 inches) of your divorce decree
- Adoption furnish a copy (no larger than 8 1/2 x 11 inches) of your adoption papers
- Court Order furnish a copy (no larger than 8 1/2 x 11 inches) of your name change
- Naturalization If you have had a name change by naturalization, use the form at [http://www.oregon.gov/BME/Emeritus/VE\\_Naturalization.pdf](http://www.oregon.gov/BME/Emeritus/VE_Naturalization.pdf).

If any of your documents are in a foreign language, you must also furnish an official translation attached to the copy of the document.

**Naturalization Affidavit Form:** Since it is a violation of law to copy a Naturalization document, the Oregon Board requests that you complete a form (provided by the Board) stating the naturalization number and date and place of naturalization. If your name has changed due to naturalization, use the form at [http://www.oregon.gov/BME/Emeritus/VE\\_Naturalization.pdf](http://www.oregon.gov/BME/Emeritus/VE_Naturalization.pdf). Do not submit a copy of your naturalization paper.

**Medical/Osteopathic Diploma:\*\***

A copy of your diploma showing graduation from a school of medicine/osteopathy/podiatry that grants a degree of Doctor of Medicine or Doctor of Osteopathy. If the diploma is written in a foreign language, furnish an official translation attached to the copy of the diploma.

**Fifth Pathway Certificate:** A copy of your Fifth Pathway certificate showing that such a program has been completed. A Fifth Pathway year does not count towards the accredited training required.

**American Specialty Board Certificate:** A copy of the certificate issued by the American Specialty Board in your specialty. If certificate is not available, submit a copy of the result letter notifying you of your Diplomat status.

**American Specialty Board Recertification Certificate:** A copy of the certificate showing recertification issued by the American Specialty Board in your specialty. If certificate is not available, submit a copy of the result letter notifying you of recertification status.

<b>Letter Requesting Waiver of SPEX Examination</b>
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Physician applicants (MD/DO) may be required to take the SPEX or COMVEX examination if completion of postgraduate training, Board certification or recertification was obtained 10 or more years prior to filing an application for Oregon licensure, or the applicant ceased practice for 24 or more consecutive months immediately prior to applying for a license in Oregon. These exams are



given on an ongoing basis. **If an examination is required, Oregon practice would be delayed until the examination has been passed.**

If you wish to request a waiver of the SPEX or COMVEX examination, you must submit a request in writing and provide documentation of continuing medical education for the past 1-3 years, or have a letter sent directly to the Board stating you have been granted an appointment as a professor or associate professor at the Oregon Health and Science University.

Your request will be reviewed by the Board's Executive Director who may grant a waiver of the examination depending on how long you have been out of practice, or your request may be referred to the Administrative Affairs Committee (AAC) of the Board for review at their next meeting. This will require that ALL processing of your file be complete by at least one month prior to the AAC meeting. The AAC meets quarterly, each March, June, September and December. The dates of the AAC meetings can be found at <http://egov.oregon.gov/BME/phyappdeadlinedates.shtml>.

Further details for requesting a waiver of the SPEX can be seen at [Notice to Oregon SPEX Applicants and Request for SPEX Waiver \(http://egov.oregon.gov/BME/MD-DO\\_Application/Spex-Exam-memo.pdf\)](http://egov.oregon.gov/BME/MD-DO_Application/Spex-Exam-memo.pdf).

**Please be advised that if you request a waiver of the SPEX or COMVEX examination, licensure would be delayed until you are either granted approval of the waiver or take and pass the examination.**

#### **Fingerprint Cards**

Pursuant to ORS 677.265 (9), applicants for licensure by the Oregon Medical Board must provide fingerprints as set forth in the above mentioned statute in order for the Board to conduct a state and federal criminal history record check. All fingerprints are processed through the Oregon State Police (OSP) and the FBI. Fingerprints must be submitted on form FD-258, which will be mailed to applicants upon receipt of application, or can be obtained from local law enforcement offices.

Fingerprint cards must be completed properly ([example](#)), with all of the identification information filled out according to the [instructions](#). The applicant must sign the card in the presence of the official taking the prints, who will also sign the card. **In addition**, the official taking the prints must complete an [Identification Verification form](#) verifying the identity of the applicant at the time of printing.

**Fingerprint cards returned to the board without this form will be rejected and applicants will be required to submit new prints – this will delay licensure.** Applicants will be required to show picture identification (i.e., driver's license, state issued identification card, military identification card, passport) at the time of fingerprinting.

Completed fingerprint cards are to be returned to the Oregon Medical Board along with the Identification Verification form. **Do not send the fingerprint cards directly to the FBI or OSP.**

The prints themselves must be of a quality meeting FBI standards, which are printed on the back of each fingerprint card. If the instructions are not followed, or the fingerprints do not meet FBI standards, the cards may be rejected by the Oregon Medical Board, OSP, or FBI. Rejected cards are sent back to the applicant with new cards for resubmission. This will delay the application process. **All applicants are therefore urged to complete this step of the application process early so as not to delay licensure.**

Fingerprinting services are available from local law enforcement agencies and can be found under fingerprinting services in the yellow pages. Fees for fingerprinting services may vary.

Questions regarding this procedure can be submitted by email to the Licensing Department at [bme.fingerprints@state.or.us](mailto:bme.fingerprints@state.or.us).

## DISCIPLINARY INQUIRY FORMS

### **Federation of State Medical Boards (FSMB)**

Board staff will query the Board Action Data Bank for the applicant.

### **National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank**

Board staff will query the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank for the applicant.

## VERIFYING YOUR CREDENTIALS

You must request verifications of the following **to be submitted directly to the Board office from the source**. Verifications must be:

- Original
- Currently dated. Verifications of employment/practice from where you are currently employed or practicing that are dated more than three months prior to the receipt of your application by the Board must be re-submitted with a current verification.
- On letterhead, computer-generated form, or board-provided form.
- **Faxed responses are not accepted.**

Some of the following agencies may require a fee in order to provide the information requested. Contact the agency directly to determine this, as not submitting the correct fee will delay the response.

If time is short, you may wish to use Federal Express or a similar service to send the required verification forms to the sources for completion. You may also wish to include a prepaid express form for the source to use to expedite a response to this Board, but the envelope must indicate that documents came directly from the source, not from the applicant.

**\*\*NOTE: For applicants who have been initially licensed a number of years ago, the Board will accept a certified copy of the Dean's letter, Verification of Medical Education, medical school diploma, and postgraduate training verifications sent directly from another state medical board in lieu of direct source verification.**

### ***Verification of Medical Education\*\****

Send the Verification of Medical Education form to the Dean/Registrar of each medical/osteopathic school attended. The form must be completed fully, showing dates of attendance and exact date of graduation. The form must show any leaves of absence, repeated years, whether the student was accepted as a transfer student, etc. An official of the school must sign the form and the school seal must be affixed.

### ***Dean's Letter of Recommendation\*\****

This letter is the one already in your medical school file, **written by the Dean** while you were a student at the school. A copy of this letter directly from your medical school to the board is acceptable. If your school does not or did not produce a Dean's letter please have the school send a transcript in lieu of the letter.

***Clinical Clerkship Verification (foreign graduates only)***

Send the form directly to the appropriate official of your medical school and ask that verification of all clerkships completed be provided directly to the Board. The form must show the time spent in each clerkship, and that each clerkship was satisfactorily completed. An official of the school must then sign the form. When you file your application for licensure, please submit a copy of each clerkship form you are submitting to your school.

A verification of clerkships is **not** required if **all** clerkships were served in the country where your medical school is located. If this is the case, please return the blank clerkship form with a notation "All clerkships served in country of medical school".

***ECFMG/Fifth Pathway***

Please send the Request for Status Report of ECFMG Certification form to the Educational Commission for Foreign Medical Graduates (ECFMG) for verification of your status. This form must be completed by the ECFMG Commission and returned directly to this Board. Verification of your status by the ECFMG and the examinations leading to this certification can also be obtained at

<http://www.ecfm.org/2006ib/ibcert.html#confirmstatus>

215-386-5900

[info@ecfm.org](mailto:info@ecfm.org)

***Fifth Pathway***

A letter is required from the Program Director, Chairman or other official of the Fifth Pathway hospital, sent directly to this Board verifying the specific beginning and ending dates of the Fifth Pathway and including an evaluation of overall performance.

***Internship/Residency/Fellowship\* \****

Send the form directly to the Director of Medical Education, Residency Program Director, Chairman of the Department, or other official of **all** internship, residency, or fellowship hospitals in the United States and foreign countries where you obtained training. The response received must verify specific beginning and ending dates of training and must include an evaluation of overall performance. This information may be provided to the Board on hospital letterhead. The form should be placed in an envelope of the hospital institution that is sending the form.

***Private/Clinic Practice/Employment/Locum Tenens Assignments***

Send the form directly to the Director or other official of each hospital, clinic, etc., where you were employed or practiced in the past five (5) years, in the United States or foreign countries. This form, or a letter sent directly to the Board, must include specific beginning and ending dates of association as well as an evaluation of overall performance. This information may be provided to the board on official letterhead. The form should be placed in an envelope of the hospital institution that is sending the form. Verifications of employment/practice from where you are currently employed or practicing that are dated more than three months prior to the receipt of your application by the Board must be re-submitted with a current verification. *Only employment verification for the past five (5) years is required unless you are advised otherwise by the Board.*

***Hospital Staff Memberships***

Send the form directly to the Director or other official of each hospital in the past five (5) years where you have had staff privileges for practice and locum tenens, for verification of temporary, provisional, courtesy, active, etc. This form must be sent directly to this Board, and must include specific beginning and ending dates of staff membership, an evaluation of performance as well statement as to whether the privileges have ever been restricted, denied, revoked, etc. This information may be provided to the Board on hospital letterhead. The form should be placed in an envelope of the hospital institution that is sending the form. *Only verification of privileges for the past five (5) years is required unless you are advised otherwise by the Board.*

### ***Locum Tenens***

Applicants must provide the Board with the names and addresses of employment and hospital privileges obtained for all locum tenens and the dates of each. Locum tenens of less than one month do not need to be verified. However, if you return to the same practice several times, a letter would be required. Applicants employed by a locum tenens agency must also request that agency to provide the Board with a list of employment locations (name and address) and a list of hospitals where the applicant has worked.

### ***State or Province Licensure***

Send the form directly to an official of the Board in the state or province where you are licensed in the United States or Canada where you are **currently** practicing or where you have **most recently** practiced. This form or a letter (on Board letterhead or computer-generated) must be sent directly from the state or province showing license number, date issued, grades if applicable, disciplinary actions (past and present), and current status with the Board. A certified copy of all legal documents is required. **Contact the appropriate board in advance as most charge a verification fee.**

## **OFFICIAL GRADE CERTIFICATION**

Contact the National Board of Medical/Osteopathic, the Medical Council of Canada or Federation of State Medical Boards and ask that grades be sent to the Oregon Board. Contact information is below.

### ***National Board of Medical Examiners (MD)***

Applicants for licensure who have completed the National Board of Medical Examiners (NBME) examination, must request that grades be sent directly to the Oregon Board. Please access the NBME web site at:

[www.nbme.org/programs/nbmecert.asp](http://www.nbme.org/programs/nbmecert.asp)  
Examinee Records Office (215) 590-9592

### ***National Board of Osteopathic Medical Examiners (DO)***

Applicants for licensure who have completed the National Board of Osteopathic Medical Examiners (NBOME) examination must request that grades be sent directly to the Oregon Board. Please contact the NBOME at:

National Board of Osteopathic Medical Examiners, Inc.  
8765 West Higgins Rd., Ste 200  
Chicago , Illinois 60631-4101  
(773) 714-0622  
[www.nbome.org](http://www.nbome.org)

### ***Licentiate Medical Council of Canada (LMCC)***

Applicants for licensure who have completed the examination administered by the Medical Council of Canada must request that grades be sent directly to the Oregon Board. Please contact the Medical Council of Canada at:

Medical Council of Canada  
100 - 2283 St. Laurent Blvd  
Ottawa , Ontario , Canada K1G 5A2  
(613) 521-6012  
<http://www.mcc.ca/english/registration/copyresult.html>

**Federation of State Medical Boards**

Applicants who have taken the complete USMLE, FLEX or SPEX examinations must contact the Federation of State Medical Boards (FSMB) and ask that grades be sent directly to the Oregon Medical Board. The Oregon Board currently uses a service offered by the FSMB called eTranscripts, which allows the Board to receive an electronic version of official USMLE, FLEX and SPEX transcripts. This service expedites the process of document submission for applicants. Please access the FSMB web site at:

[www.fsmb.org/transcripts.html](http://www.fsmb.org/transcripts.html)

(817) 868-4041

**MEDICAL PRACTICE ACT AND DRUG ENFORCEMENT ADMINISTRATION LAWS -- STUDY MATERIAL AND OPEN-BOOK EXAMINATIONS CONCERNING THIS MATERIAL**

Copies of the Medical Practice Act (Chapter 677), Oregon Administrative Rules (Chapter 847), Practitioner's Manual explaining State and Federal DEA Laws, a small portion of the DEA's Pharmacist Manual, and the Doctor Title Law (ORS 676.100-.140) are provided as a resource for the two open-book examinations.

**Instructions for Downloading the MPA/DEA Exams**


**Items 1 – 7 are needed to complete the open-book exams and may be viewed online or printed. All applicants must download, print, and complete the open-book exams to be mailed to the Board.**

**NOTE: There is only ONE answer per question.**

For instructions on how to use our new fill-in forms, [click here](#).

1.	<a href="#">Oregon Revised Statutes, Chapter 677</a>
2.	<a href="#">Oregon Administrative Rules, Chapter 847</a>
3.	<a href="#">Doctor Title Law</a>
4.	<a href="#">Practitioner's Manual</a>
5.	<a href="#">Pharmacist Manual – Narcotic Treatment Programs</a>
6.	<a href="#">Exam—Drug Enforcement Administration/ Controlled Substance List</a>
7.	<a href="#">Exam—Medical Practice Act</a>

**To fill out a form:**

1. You must have Adobe 4.0 or higher.
2. Click on the form you want to use. This will open it in Adobe.
3. Select the hand tool. 
4. Position the pointer inside a form field, and click. The I-beam pointer allows you to type text. The arrow pointer allows you to select a button, a check box, a radio button, or an

item from a list.

5. After entering text or selecting an item, check box, or radio button, do one of the following:
  - o Press Tab to accept the form field change and go to the next form field.
  - o Press Shift+Tab to accept the form field change and go to the previous form field.
  - o Press Enter (Windows) or Return (Mac OS) to accept the form field change and deselect the current form field.
6. When you have finished filling out the form, print the document and mail it to the OMB with any required payment. Don't forget to sign and date the form if applicable.

Applicant #	License #	Date License Issued:
SPACE ABOVE THIS LINE FOR BOARD USE ONLY		

## APPLICATION FOR A VOLUNTEER EMERITUS LICENSE

<b>1. FULL LEGAL NAME</b> Last name (Jr., II, etc.)	First Name	Middle	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM
<b>2. OTHER NAMES YOU HAVE BEEN KNOWN BY:</b> Last Name	First Name	Middle Name	

*Please see the terms and conditions of use for the Online Status Report in the Agreement at [www.oregon.gov/BME/agreement.pdf](http://www.oregon.gov/BME/agreement.pdf).*

<b>3. CURRENT PRACTICE ADDRESS/TRAINING STREET ADDRESS</b>	City	State	Zip
<b>4. CURRENT RESIDENCE ADDRESS (IF APPLICABLE)</b>	City	State	Zip
<b>5. CURRENT OTHER STREET ADDRESS (IF APPLICABLE)</b>	City	State	Zip
<b>6. PRACTICE/TRAINING TELEPHONE</b>	<b>7. RESIDENCE TELEPHONE</b>		<b>8. OTHER TELEPHONE</b>
<b>9. E-MAIL ADDRESS</b>		<b>10. SOCIAL SECURITY NUMBER</b>	
Please indicate your mailing address: <input type="checkbox"/> Practice/Training <input type="checkbox"/> Residence <input type="checkbox"/> Other			

<b>11. PREMEDICAL EDUCATION</b> Name and location of college/university			
BEGINNING DATE	ENDING DATE (Mo., Yr.)	DEGREE	DATE OF DEGREE
<b>12. ADDITIONAL PREMEDICAL EDUCATION</b> Name and location of college/university			
BEGINNING DATE	ENDING DATE (Mo., Yr.)	DEGREE	DATE OF DEGREE

13. MEDICAL EDUCATION Name, location of Medical/Osteopathic/Podiatric School	DATES OF ATTENDANCE	BEGINNING DATE Mo. Day Yr.	ENDING DATE Mo. Day Yr.
	1 <sup>st</sup> Year		
	2 <sup>nd</sup> Year		
	3 <sup>rd</sup> Year		
	4 <sup>th</sup> Year		
	5 <sup>th</sup> Year		
	6 <sup>th</sup> Year		
<b>14. MEDICAL/OSTEOPATHIC/PODIATRIC SCHOOL GRADUATED</b> School, City, State/Country		DEGREE (Mo., Day, Yr.)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM

15. **EXAMINATION.** Indicate the examination(s) you have taken.

<input type="checkbox"/> USMLE	<input type="checkbox"/> Step 1	Date Passed _____	<input type="checkbox"/> Step 2	Date Passed _____	<input type="checkbox"/> Step 3	Date Passed _____
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<input type="checkbox"/> NBME (MD)	Date Passed _____	<input type="checkbox"/> Part I	Date Passed _____	<input type="checkbox"/> Part 2	Date Passed _____	<input type="checkbox"/> Part 3	Date Passed _____
<input type="checkbox"/> NBOME (DO)							
<input type="checkbox"/> NBPME (DPM)							

<input type="checkbox"/> FLEX	<input type="checkbox"/> Day 1	Date Passed _____	<input type="checkbox"/> Day 2	Date Passed _____	<input type="checkbox"/> Day 3	Date Passed _____
		State where taken _____		State where taken _____		State where taken _____
<input type="checkbox"/> FLEX	<input type="checkbox"/> Comp 1	Date Passed _____	<input type="checkbox"/> Comp 2	Date Passed _____		

<input type="checkbox"/> LMCC	Date passed _____
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<input type="checkbox"/> SPEX	State where taken _____	Date passed _____
<input type="checkbox"/> COMVEX		

<input type="checkbox"/> ECFMG	Date Passed _____	Date certificate issued _____
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16. ALL LICENSES APPLIED FOR: (even if not current) State/province/country	TYPE (MD/DO/DPM, RN, EMT, PA,)	LICENSE/CERTIFICATE Issued		GRANTED	EXPLAIN		PERM or TEMP	CURRENT	
		Mo/Yr	Number		Denied (explain)	Pending		Yes	No

17. Have you ever applied for or obtained an unlimited or limited license in the State of Oregon?  
 NO     YES    If Yes, Show License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

18. STAFF PRIVILEGES. List ALL hospitals in which you have ever applied for staff privileges for practice or military service. Do NOT include hospital training programs. (Use only standard abbreviations). A curriculum vitae is NOT acceptable.

NAME OF HOSPITAL Complete Address	Granted	Explain			Hospital Usage Daily/Monthly	Dates (Mo Yr)	
		Denied	Pending	Restricted		FROM	TO

I HAVE NEVER APPLIED FOR NOR OBTAINED STAFF PRIVILEGES IN ANY HOSPITAL. Please explain below.

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**19. CHRONOLOGY OF ACTIVITIES.** List **ALL** activities including training, employment, locum tenens, vacations in date order after medical/ osteopathic/podiatric school up to and including the present date. Account for all periods of time and indicate specialty field for all training programs. Use standard abbreviations. Only list vacations of one month or longer between activities. **(A curriculum vitae is NOT acceptable.)**

TYPE OF ACTIVITY (training, practice, vacation)	TRAINING LEVELS	SPECIALTY	NAME OF INSTITUTION OR PLACE OF PRACTICE AND MAILING ADDRESS	BEGINNING DATE		ENDING DATE	
				Mo	Yr	Mo	Yr
<b>EXAMPLE</b> Internship	PG1	Rotating	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	7	97	6	98
Residency	PG 2 and 3	Internal Med	Yale Univ. Sch Med., 333 Cedar St., New Haven, CT 06520	7	98	6	00
Private Practice - Group		Internal Med	10 Oak Grove Rd, Stamford, CT 06907	7	00	11	06

**LIST ALL ACTIVITIES (TRAINING, PRACTICE, VACATION BETWEEN ACTIVITIES ONLY) UP TO PRESENT DATE**

**20. PERSONAL HISTORY QUESTIONS.** The answers to some of these questions may be exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

Answer all questions. If you answer “yes” to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application. Use the form at [http://www.oregon.gov/BME/Emeritus/VE\\_Personal\\_History\\_Explan\\_Form.pdf](http://www.oregon.gov/BME/Emeritus/VE_Personal_History_Explan_Form.pdf).

**NOTE:** Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including a fine, denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

### Category I

YES NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you hold, or have you ever held, any licenses to practice another health care profession?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever failed a licensing examination, or any portion of a licensing examination, for a medical license (USMLE, NBME, NBOME, FLEX, ECFMG) or for any other health professional license? <i>If you ever failed a portion of a licensing examination you must answer “yes” even if you later passed the examination.</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever been asked to and/or permitted to withdraw an application for licensure, for credentialing, or for certification with any board, agency or institution?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has any state licensing board refused to issue, refused to renew or denied you a license to practice?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you ever had any disciplinary or adverse action imposed against any professional license or certification, or were you ever denied a professional license or certification, or have you entered into any consent agreement, stipulated order or settlement with any regulatory Board or certification agency; or have you ever been notified of any complaints or investigations related to any license or certification? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever been arrested, convicted of, or pled guilty or “nolo contendere” to ANY offense in any state in the United States or any foreign country, other than minor traffic violations?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever been contacted by or asked to make a response to any governmental agency in any jurisdiction regarding any criminal or civil investigation of which you are the subject, whether or not a charge, claim or filing with a court actually occurred?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you aware of any current, proposed, impending or threatened civil or criminal action against you? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever entered into any formal, informal, out-of-court or confidential settlement to deter, prevent, or settle a claim, lawsuit, letter of intent to sue, and/or criminal action? <i>This includes whether or not a claim, charge or filing was actually made with a court.</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Has any award, settlement or payment of any kind ever been made by you or on your behalf to resolve a malpractice claim, even if it was not required to be reported to the National Practitioner Data Bank (NPDB); or have you ever been notified in any manner that any such claim is proposed, pending or threatened, whether or not a claim, charge or filing was actually made with a court?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?  |

13. Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, received a warning or been subject to any disciplinary action during medical school or postgraduate training?
14. Have you ever had privileges denied, reduced, restricted, suspended, revoked, terminated or have you been placed on probation, been subject to staff disciplinary action or non-renewal of an employment contract, or been requested to voluntarily resign or suspend your privileges while under investigation from a hospital, clinic, surgical center, or other medically related employment; or have you ever been notified that such action or request is pending or proposed? Have you been allowed to withdraw your staff privileges from a hospital or surgical center?

### Category II

“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

YES NO

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently? Has there been any type of inquiry into your physical, mental, or emotional health within the past 5 years?
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition?
3. Do you currently have, or have you had within the past 5 years, a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?
4. Within the past 5 years, have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)? *“Excessive” as used in this question means the use of alcohol or drugs that leads to disturbances, fights, arrest, injury, accident, illness, loss of consciousness, or other adverse consequences.*
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC? Have you refused to submit to any such test? *This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional, unless the test was conducted as part of a criminal investigation, such as DUII.*
6. Within the past five years, have you entered into a diversion program for evaluation, treatment or monitoring for substance abuse or dependency, or for correction of communication or boundary issues, in lieu of or as a condition of resolving a matter before a health care program or facility, regulatory or licensing Board, or criminal or civil court; or have you been notified that such action is pending or proposed?

21. <b>DATE OF BIRTH</b> (Mo. Day Yr.) _____			<b>ATTACH (STAPLE) PHOTOGRAPH HERE. SIGN YOUR NAME IN INK &amp; SHOW DATE TAKEN ON FRONT OF PHOTOGRAPH.</b>  <b>PHOTOGRAPH MUST BE:</b> 1. An original, passport quality photograph. No scanned or Polaroid photographs with thick backing. 2. Close-up front view of head and shoulders (not a profile). 3. No larger than 2" x 3" and no smaller than 2" x 2". 4. Taken within <b>90 days</b> prior to filing this application. 5. Signed in ink showing date taken on front of photograph.
22. <b>PLACE OF BIRTH</b> City, State, or country _____			
<b>23. PHYSICAL DESCRIPTION</b> HEIGHT _____ WEIGHT _____	EYES _____	HAIR _____	
24. <b>GENDER</b>  <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
25. <b>MILITARY SERVICE</b> (Branch) _____ FROM (Mo. Day Yr.) _____ Active Duty Only TO (Mo. Day Yr.) _____ (Branch) _____ FROM (Mo. Day Yr.) _____ TO (Mo. Day Yr.) _____			
26. <b>MEDICAL SPECIALTY</b> Primary specialty you plan to practice in Oregon _____			
<b>27. OREGON PRACTICE INFORMATION</b>			
Hospital/Clinic. Medical group _____			
Street address _____			
City, state, zip _____			
Proposed <b>Beginning Date</b> of Practice: _____			
<b>28. AMERICAN BOARD CERTIFICATION:</b> Below list any certifications or recertifications you have obtained for any of the following boards: <ul style="list-style-type: none"> <li>American Board of Medical Specialties (ABMS)</li> <li>American Osteopathic Association's Bureau of Osteopathic Specialists (AOA--BOS)</li> </ul>			
<b>SPECIALTY BOARD</b>	<b>CERTIFICATE NO.</b>	<b>CERTIFIED</b> (Mo. Day Yr.)	
<b>SPECIALTY BOARD</b>	<b>CERTIFICATE NO.</b>	<b>CERTIFIED</b> (Mo. Day Yr.)	
<b>SPECIALTY BOARD</b>	<b>CERTIFICATE NO.</b>	<b>RECERTIFIED</b> (Mo. Day Yr.)	
<b>SPECIALTY BOARD</b>	<b>CERTIFICATE NO.</b>	<b>RECERTIFIED</b> (Mo. Day Yr.)	


**RELEASE/AFFIDAVIT OF APPLICANT**

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the  
(Applicant, TYPE or PRINT full legal name)  
person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the state of Oregon, particularly those acts set forth in Sections ORS 677.080 or 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), which includes state medical licensing boards, and the Federation of State Medical Boards, to release to this licensing board any information, files or records requested by this board in connection with the processing of this application. I further authorize this board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine/podiatry during the processing of this application and the time that I am a licensee of this board. I have read and understand the terms and conditions of use for the Online Status Report in the Agreement at [www.oregon.gov/BME/agreement.pdf](http://www.oregon.gov/BME/agreement.pdf).

I have read carefully the questions in the foregoing application and I have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act is grounds for the denial, suspension or revocation of my license to practice medicine in the state of Oregon.

\_\_\_\_\_  
(Applicant to sign usual **business** signature in presence of Notary Public)

Subscribed and sworn to me before this _____ day of _____ 20____
Notary signature  _____
Notary Public for _____
My commission expires _____

Affix a Legible Seal in This Space

**NOTARIZE ON THIS FORM ONLY**